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Quality standards

Consultation summary report: depression in adults (update)

Quality Standards Advisory Committee post-consultation meeting: 22 March 2023.

1. Introduction

The draft quality standard for depression in adults (update) was made available on the NICE website for a 4-week public consultation period between 17 January and 14 February 2023. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 8 organisations, which included service providers, national organisations, professional bodies and others. 2 organisations advised ‘no comment’.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in the Appendix.

**Note**: On 16 January 2023 it was announced in [blog post published by NHSE (Professor D M Clark and Adrian Whittington)](https://www.england.nhs.uk/blog/whats-in-a-name-nhs-talking-therapies-for-anxiety-and-depression-the-new-name-for-iapt-services/) that Improving Access to Psychological Therapies (IAPT) would be known as NHS Talking Therapies. IAPT services are referred to as NHS Talking Therapies services in this report.

1. Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Stakeholders were also invited to respond to the following statement-specific questions:

4. For draft quality statement 3: Can the population for the statement’s denominator – adults with depression who are at a higher risk of relapse (see definitions section) - be identified in practice? Please give reasons for your answer

1. General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

* Stakeholders generally supported the standard, commenting that it reflects important areas, and best practice for NHS Talking Therapies services.
* Does not address the needs of adults with an existing diagnosis of depression.
* Supports a holistic approach and does not focus on antidepressants being prescribed first.
* Some concern that the standard does not fully recognise the role of social and environmental factors (life experiences and stressors) in depression. The importance of adults with depression being able to access practical support was also highlighted.
* Delivering holistic assessment and treatment planning needs alignment and change within and between different systems; some services may need to rethink their approach. Need for coordination between healthcare professionals was also highlighted.
* Concern that the standard assumes that all adults with clinical depression can access a system delivering assessment, diagnosis, treatment and review.
* Limited use of outcome measures in the standard.

### Consultation comments on data collection

* Conflicting views regarding feasibility in NHS Talking Therapies services:
  + Bespoke systems may be required.
  + Concern that medical records may not contain enough information on relevant life experience and potential causal factors.
* Accurate SNOMED coding is needed.
* Conflicting views regarding secondary care; systems are not currently available but they could be readily arranged. Collection of routine data is not as well established as in NHS Talking Therapies services.

### Consultation comments on resource impact

* Mixed response: all statements apart from number 3 align with best practice in NHS Talking Therapies services.
* Could be achieved through deployment of additional professional roles. Others highlighted a severe shortage of capacity in primary and secondary care.
* Longer appointments required, which could also negatively affect already lengthy waiting lists (highlighted as a barrier to access).
* Additional training to enable mental health professionals to recognise communication needs.
* Local investment (and communication) needed to provide information in accessible formats.
* Closure of services in some areas could be mitigated by community-based initiatives to deliver early and holistic support; these may achieve cost-savings.

1. Summary of consultation feedback by draft statement
   1. Draft statement 1

### Adults who may have depression have a comprehensive assessment. [2011, updated 2023]

### Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

* Some support for its inclusion but concern that it represented a minimum standard for assessment.
* Does a standard for assessment exist?
* Refer to using rating scales and outcome measures as part of the assessment.
* Does the statement apply to adults with a previous episode of depression?
* Additional training required to deliver complex and culturally appropriate assessments.
* Waiting lists and not accessing the system in the first place within the community are potential barriers.

Statement

* Assessment should additionally refer to:
  + Assessment for coexisting mental health conditions as these may impact treatment for depression.
  + Recognising communication needs.

Rationale

* Replace “enables an accurate diagnosis” with “reach a shared understanding of presenting issues”.
* Reference mentioning external agencies to address ongoing social and environmental factors; the last line overstates the link between accurate diagnosis and effective treatment.

Measures

* There were some concerns around measurement:
  + Lack of existing routes for recording that an assessment has been completed.
  + Suggestion to include guidance on checking records.
  + Template would be useful to address potential for diagnostic overshadowing (attributing symptoms to other conditions or environmental factors) especially in primary care.
* Suggestion to include a) offering medication and b) referral for psychological therapy.

Definition (comprehensive assessment)

* Highlight the assessment covers discussion of the impact of past (including childhood experiences) and ongoing social and environmental factors (stressors)
* Refer to risk assessment (for suicide) and developing an individualised safety plan.
* Refer to additional examples of stressful or traumatic life events.

Equality and diversity considerations

* Change “culturally sensitive” to “culturally competent”.
* Explain what “using language which takes account of the person’s family and wider context” means in practice.
* Refer to asking about experiences rather than symptoms; adults and carers may not identify their experiences as being relevant to depression.
* Include community navigators and peer support workers.
* Refer to consulting with a speech and language therapist as they are key to supporting communication needs.

### Issues for consideration

#### For discussion:

* Is the population for this statement all adults with depression (new or subsequent episode)? If so, should the process measure be amended to refer to adults with “a new episode of depression”?
* Confirm that the same assessment is done if adults are presenting (regardless of timescale) with a second or any subsequent episode?
* How significant are concerns around the need for longer appointment times and additional training?
* Should the statement definition refer to risk assessment?
* Are concerns around diagnosis of coexisting mental health conditions addressed by the rationale?
* Are concerns about the importance of recognising communication needs and how to adapt the assessment addressed by the E&D section?
* Does the statement (and definition) highlight sufficiently that the assessment should not focus solely on depression and include discussion of social and environmental factors?
* Can we confirm that “recent” (source recommendations) experience does not encompass “ongoing” experience?
* How significant are concerns around diagnostic overshadowing?
* Should formal rating scales and outcome measures be included?
* Should the equality and diversity section be amended?

#### For decision:

* Should the statement be retained in the standard?
* Confirm the population and wording of the process measure.
* Do concerns on assessing coexisting mental health conditions need addressing and if so how?
* Should the definition of the assessment be amended?
  + How can an accurate diagnosis of depression be verified in practice?
  + Add (if supported by recommendations) additional examples of trauma?
  + Refer to risk assessment?
* Does the E&D section address the importance of recognising communication needs? Are other amendments required?
* Should outcome measures be added?
* Are other amendments required?
  1. Draft statement 2

### Adults with a new episode of depression discuss the full range of treatment options with their healthcare professional [new 2023].

### Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

* General support for the statement; it should be achievable in NHS Talking Therapies services and reflects current practice.
* Barriers highlighted; GPs:
  + tend to prescribe antidepressants as first-line treatment.
  + may not always discuss key aspects of different psychological therapies.
* A full assessment may not have been completed, due to:
  + Lack of time (GPs).
  + Reluctance or inability to participate (adults who have been sectioned).
* Experience and ability of the assessor is critical; need for additional training to enable all healthcare professionals to have enough knowledge of psychological therapies.
* When discussing preferences for the full range of therapies professionals should openly acknowledge that the preferred option may be unavailable; not routinely recording preferences means that these are not documented and so could perpetuate shortages
* Refer to discussing adults’ own ideas on what has helped previously.
* Coexisting conditions may need to be addressed first.

Statement

* Amend to “service users should have a full and informed choice of treatment options and that their care plan is cocreated between them and their treatment provider.”

Rationale

Refer to matching choice of treatment to communication and cognitive abilities.

Measures

* Concerns around feasibility; adults being given information about a range of psychological therapies is a potential outcome measure.

Audience descriptors

* Refer to a mechanism for services not being penalised if supporting services have not been commissioned.
* Healthcare professionals need to be aware of the role of social and environmental factors in depression; these could be addressed by signposting to external agencies.

Definitions

* New episode of depression: Suggestion to include the Hamilton scale (for use in community settings).
* Treatment options: Suggestion to include recovery-oriented interventions.

Equality and diversity section

* Highlight that the implications of offering remote online delivery around meeting individual needs, including accessibility.
* Using antidepressants in pregnancy and while breastfeeding should be mentioned.

**Issues for consideration**

#### For discussion:

* How significant are identified barriers to implementation?
* Is the focus of the statement the discussion or the treatment plan?
* What are the implications of local variation in the extent of available treatment options for the discussion?
* Should the statement highlight potentially needing to treat any coexisting conditions first?
* Do treatments recommended in the development sources include recovery- oriented interventions?
* Is the current outcome measure appropriate?
* Should additional equality and diversity considerations be added?

#### For decision:

* Should the statement be retained in the standard?
* What amendments are needed?
  1. Draft statement 3

### Adults with depression who are at a higher risk of relapse are offered relapse prevention interventions. [2011, updated 2023]

### Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

* Inclusion was generally welcomed, but stakeholders raised significant concerns around resource impact:
  + Represents a significant change in practice within NHS Talking Therapies services.
  + Insufficient number of trained mindfulness-based cognitive behaviour therapy (MCBT) practitioners.
  + Many services currently offer up to 2 sessions of relapse prevention work at the end of one-to-one therapy; for this group, the statement could result in their treatment being discontinued. Consequently, adults may drop out of treatment.
  + Concerns about waiting times for group therapy.
  + Query about how many group therapy sessions should be offered.
* Does not address contributory social and environmental factors (including stressors). Reference to signposting to external agencies to address these should be included.
* Include information about the interventions, such as CBT, DBT (dialectical behavioural therapy).

Measures

* Include the number asked about ongoing stressors, and of the number of those where such stressors were identified, the number signposted or supported to access appropriate agencies.

Audience descriptors

* Assessment (discussion) should identify ongoing stressors and environmental factors. Audience descriptors should be amended accordingly, for example:
  + Patient descriptor: include asking about any ongoing stressors contributing to their depression, whether they have been able to access support with these, and that they should expect to be signposted to relevant agencies.

Definitions

* Should additional examples of personal, social and environmental factors be added?

### Consultation question 4

For draft quality statement 3: Can the population for the statement’s denominator – adults with depression who are at a higher risk of relapse (see definitions section) - be identified in practice? Please give reasons for your answer.

Stakeholders made the following comments in relation to consultation question 4:

* Conflicting views regarding feasibility. Measurement would be supported by recording a thorough history, including social and environmental factors and by engagement and close working between patients and therapists. However, concerns were raised:
  + Difficult and time-consuming to identify the population: it is not consistently coded; free-text is used for some of the information required. An identifying code should be developed to enable automation.
  + Some elements of defining the population are subjective.
  + Current systems make it difficult to report on those discharged from mental health services.
* Rating scales (rely on adults reporting their symptoms and interpretation by professionals) could be used to record levels of socioeconomic and environmental factors, providing a baseline standard against which to assess the impact of sessions. However some adults may mask symptoms and feelings of self-harm during assessment.
* Further training needed on delivering complex assessments and around the impact of physical health problems and their implication for risk of relapse.

### Issues for consideration

#### For discussion:

* How significant are the resource impact concerns around workforce capacity and skills? What are the implications for implementation?
* Is measurement feasible?
  + Will patient records provide enough information about history, including social and environmental factors?
  + Are stakeholder concerns around inconsistency and shortfalls in coding significant? Is a validated tool available?
  + Should more detail be added to the definition “relapse prevention interventions”?
* Should the definition of “adults with depression at a higher risk of relapse” be amended?

#### For decision:

* Should the statement be retained in the standard?
* Is the statement measurable, in light of stakeholder comments?
* Is the statement achievable, given the resource implications?
* If so, what amendments should be made?
  1. Draft statement 4

### Adults with depression who are stopping antidepressant medication have the dose reduced in stages [new, 2023].

### Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

* Some support for the statement, with stakeholders highlighting that practice varies.
* Communication between GPs and therapists is important.
* Concern around potential withdrawal symptoms is a significant barrier.
* Highlight that close monitoring is imperative.
* Consider that alternative medications such as adjunct therapy or cross-prescribing medication with lesser withdrawal may be needed.
* Does the statement cover adults who have restarted antidepressants?
* Acknowledge known uncertainty regarding an optimum withdrawal process, particularly in regard to tapering that aligns with patient choice.

Rationale

* Is an appointment is needed to determine whether withdrawal symptoms have been resolved or are tolerable before making the next reduction?

Measures

* Unclear how the statement can be measured.
* Using local systems to record data is likely to lead to substantial variation in quality; national systems should be enabled to collect it.

### Issues for consideration

#### For discussion:

* What population is covered?
* Should the statement cover adjunct medications and switching medications?
* How significant are concerns around workforce capacity to support monitoring?
* How significant are concerns around measurement?
* Should the need for monitoring be highlighted more strongly?

#### For decision:

* Should the statement be retained in the standard?
* If so, what amendments are needed?
  1. Draft statement 5

### Adults with depression from minority ethnic family backgrounds are supported to access mental health services. [new 2023]

### Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

* Strong support for the statement; some stakeholders commented that it aligns with best practice and can be achieved in NHS Talking Therapies services.
* Suggestion to include more underserved groups.
* A “one size-fits all” approach is ineffective for meeting the needs of diverse populations; diversity may also exist within as well as between communities. The following strategies could help improve access:
  + Improving awareness and understanding of the cultural and religious issues within specific communities; understanding how cultural interpretations impact access may help reduce stigma.
  + Specialist primary mental health care or culturally sensitive GP services, which recognise cultural and religious influences.
* Mental health services need to consider language barriers to support access, particularly among communities whose first language is not English. Services delivered from within adults’ own community may be more effective:
  + Interpreters may typically require training in knowledge of dialects and awareness of confidentiality in culturally-sensitive areas.
  + Adults who are newer or first-generation migrants may seek assistance from religious leaders or respected community members, with whom they can communicate more easily.
  + Community dialogue or culturally appropriate workshops may be needed to improve access within certain communities.
* Access beyond traditional routes, such as support in community locations and schools is important. This is relative to:
  + Pathways for people from a Black family background negatively affecting treatment outcomes and willingness to engage with mainstream services.
  + Statutory and voluntary sector community support are important for supporting recovery.
* Adults’ wider social context is not always considered when culturally sensitive assessments are delivered.
* SNOMED coding is necessary for collecting accurate ethnicity data.

Rationale

* Should mention discussing support, translation services and other adjustments earlier in the standard.

Measures

* Suggestion to include treatment outcomes.

Audience descriptors (services)

* Resources are likely to vary locally, affecting availability of services outside working hours.
* Likely shortage of bilingual therapists.
* Confidentiality issues may arise in community settings.

### Issues for consideration

#### For discussion:

* Can the statement be achieved in services other than NHS Talking Therapies services?
* Could the committee confirm that they are happy to focus on adults from minority ethnic family backgrounds?
* Are further examples of supporting access required?
* How can concerns around confidentiality as a potential barrier be addressed?
* How significant is the concern around local variation in access to services outside working hours?
* Is a shortage of bilingual therapists a significant resource impact issue?
* How significant are concerns around collecting accurate data on ethnicity?
* Is an outcome measure on treatment outcomes needed?

#### For decision:

* Should the statement be retained in the standard?
* Should additional groups be added?
* What other amendments are needed?

1. Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

* Relationship building from and continuing the first contact (and before diagnosis). Existing statements:
  + QS14 [Statement 1](https://www.nice.org.uk/guidance/qs15/chapter/Quality-statement-1-Empathy-dignity-and-respect): People using adult NHS services are treated with empathy, dignity and respect.
  + QS15 [Statement 1](https://www.nice.org.uk/guidance/qs14/chapter/Quality-statement-1-Empathy-dignity-and-respect): People using adult NHS services are treated with empathy, dignity and respect.
* Statement on adults being actively supported to have a comprehensive assessment, to highlight the importance of shared decision making. Existing statements:
  + QS14 [Statement 2](https://www.nice.org.uk/guidance/qs14/chapter/Quality-statement-2-Decision-making): People using mental health services are supported in shared decision making.
  + QS15 [Statement 2](https://www.nice.org.uk/guidance/qs15/chapter/Quality-statement-2-Decision-making): People using mental health services are supported in shared decision making.
* Recording health outcomes ( Previous version of QS8, statement 3).
* Starting antidepressants, including the need for discussion and advice.
* Support to treat tobacco dependence. Existing statements:
  + QS207 [Statement 1](https://www.nice.org.uk/guidance/qs15/chapter/Quality-statement-1-Empathy-dignity-and-respect): People are asked if they use tobacco at key points of contact with a health or social care professional.
  + QS207 [Statement 2:](https://www.nice.org.uk/guidance/qs207/chapter/Quality-statement-2-Advice) People who use tobacco receive advice on quitting.
  + QS207 [Statement 3:](https://www.nice.org.uk/guidance/qs207/chapter/Quality-statement-3-Tobacco-cessation-support-and-treatment) People who want to stop using tobacco are offered tobacco cessation support and treatment by a healthcare professional.

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# Appendix: Quality standard consultation comments table – registered stakeholders

| ID | Stakeholder | Section | Comments |
| --- | --- | --- | --- |
|  | **General** |  |  |
| 1 | British Psychological Society | General | The BPS supports the recognition of multiple factors affecting depression but acknowledges that the guidelines are primarily presented from a medical perspective. This may limit the holistic approach and understanding of depression. For example, Statement 1 ‘have depression’ and Statement 3 ‘risk of relapse’ carry assumptions that depression is a disease and that (primarily) the disease process may cause relapse, rather than recurrence being due to life experiences and pressures, including childhood adverse experiences and on-going social and environmental stressors. There is evidence that life experiences such as childhood adverse experiences and ongoing stressors play a significant role in depression. The draft Quality Standard appears to acknowledge this but could go further by recommending support for individuals to make these connections, validation from professionals for their experiences, and access to practical help for ongoing stressors and abuse. |
| 2 | British Psychological Society | General | Our members note that some important statements from the depression guideline about principles of care have been missed out. The first one listed on p. 8 of the 2022 Depression in Adults Guideline (section 1.1.1) is crucial: “When working with people with depression and their families or carers: build a trusting relationship and work in an open, engaging and non-judgemental manner.” Relationship building should not wait until they have a diagnosis but should begin from the first contact and continue. |
| 3 | NHS England & Improvement – Mental Health Transformation Programme Eastern region | General / Question 2 | Adults with depression are often given prescribed anti-depressants rather than being offered psychological treatment. The guidance supports holistic approach but unclear that there is any mechanism available to measure this. |
| 4 | NHS England & Improvement - National NHS Talking Therapies team | General comment | We strongly suggest that statement 1 includes explicit reference to a **comprehensive** assessment which includes assessment for co-occurring mental health conditions and one which recognises and supports communication needs, using where appropriate communication resources aimed at enabling understanding. We suggest the addition of the following text: ““Adults who may have depression have a comprehensive assessment, including identification of communication needs or co-occurring mental health conditions that may impact recommended treatment”.  We would like to propose the use “culturally competent” in place of “culturally sensitive”. We would also like to highlight additional roles beyond interpreters that may be helpful or able to support access, such as [community navigators](https://www.ucl.ac.uk/psychiatry/sites/psychiatry/files/community_navigator_programme_manual.pdf) and [peer support workers.](https://www.hee.nhs.uk/our-work/mental-health/new-roles-mental-health/peer-support-workers)  This document clearly outlines best practice guidance which should already be in place in most IAPT services.  Standard 3 regarding relapse prevention is discussed in more detail below as this presents the most significant change to practice that I am aware of for some IAPT services.  Statement 1 - There is no reference within the statement in relation to the use of outcome measures to inform the comprehensive assessment. This previously featured in the 2011 Quality standard, which stated “For details of the assessment, see appendix of NICE's guideline on depression in adults and appendix C of NICE's guideline on depression in adults with a chronic physical health problem. This should be supported by use of a formal rating scale for symptom severity (for example, Patient Health Questionnaire [PHQ-9], Hospital Anxiety and Depression Scale [HADS], Beck Depression Inventory [BDI])”. We strongly suggest that statement 1 includes explicit reference to the use of outcome measures to inform assessment and enable monitoring and evaluation of treatment.  Key areas for quality improvement – Additional quality standard needed on starting antidepressants.  When starting antidepressant treatment, I would suggest inclusion of statement/standard about the need for a discussion/advice about the general timescales for antidepressant pharmacotherapy and the need for appropriate discontinuation strategies of antidepressant |
| 5 | Royal College of Nursing | General | Excellent coverage, reflective of evidence and best practice –  - our comment relates to **comprehensive assessment** (statement 1) – this is clear and comprehensive, but might possibly benefit from (1) the addition of, within the bullet points for assessment, some note of consideration of positive / protective factors – skills, strengths and sources of support; and (2) should there be some explicit note of (suicide) risk assessment as a necessary part of an assessment, with this linking to the development of an individualised safety plan where warranted/necessary. |
| 6 | Royal College of Nursing | General | Regarding Question 2:  Page 15-21 Talking therapies, standardised counselling and 1:1 key working support in mental health substance misuse services is great for depressive episodes and relapse prevention. CBT, DBT and EMDR therapies are the gold standard. |
| 7 | Royal College of Speech and Language Therapists | General | Both QS 1 and QS 2 refer to [Improving Access to Psychological Therapies (IAPT)](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/improving-access-to-psychological-therapies-data-set/improving-access-to-psychological-therapies-data-set-reports) across several sections of the quality standard. This has recently been renamed talking therapies, so this update should be made. |
| 8 | Specialist Pharmacy Service (SPS) Medicines Advice Service UK Drugs in Lactation Advisory Service | General | There is no mention of use of antidepressants in pregnancy or breastfeeding. This is a huge cohort of patients which access these treatments, and not to acknowledge this seems hugely remiss. It would be very beneficial to link though to the CG192 Guideline at the very least. |
| 9 | British Psychological Society | Question 1 | The draft quality standard does not accurately reflect the key areas for quality improvement for adult depression. We have concerns about the phrasing of certain statements, which may negatively impact the delivery and aims of the service. Additionally, the existing population of adults with depression has not been properly considered in this draft. There is an assumption that all individuals who could be clinically depressed have access to a system that performs assessment, diagnosis, treatment, and maintenance. These factors need to be addressed to improve the overall quality of the service. |
| 10 | NHS England & Improvement – Clinical Programmes Team | Question 1 | Yes for all. |
| 11 | NHS England & Improvement - National NHS Talking Therapies team | Question 1 | The inclusion of relapse prevention interventions and the underlying rationale of quality statement #2 (“Adults with a new episode of depression discuss the full range of treatment options with their healthcare professional”) focussing on informed decision-making/choice are particularly welcomed.  This quality standard accurately reflects important areas for consideration.  Within the 2011 Quality standard there was a specific statement in relation to the recording of health outcomes. (Statement 3 – Practitioners delivering pharmacological, psychological or psychosocial interventions for people with depression record health outcomes at each appointment and use the finding to adjust delivery of interventions). This no longer features in the updated standard and there is limited specific reference to the recording of health outcomes or use of outcome measures. We would suggest that Statement 3 from the 2011 Quality standard remains relevant. Whilst information in the briefing paper referenced that IAPT services routinely collect activity and outcome data, outcome collection and reporting within secondary care services remains at a significantly lower level. |
| 12 | NHS England & Improvement – Mental Health Transformation Programme (Eastern region) | Question 1 | Yes |
|  | **Question 2** |  |  |
| 13 | British Psychological Society |  | We have concerns that the proposed information collection methods, primarily from medical records, may not provide adequate information on relevant life experience and potential causal factors. This is concerning as previous research has indicated that 80% of GPs believe that social causes play a greater role than bio-genetic causes in depression. Furthermore, larger surveys of the general population have shown that a significant portion of individuals attribute their depression to life events, with 92% respondents from one general mental health survey indicating this. Collecting information on relevant life experiences and potential causal factors is crucial in understanding depression. The BPS recommends the implementation of a unified system for data collection to ensure accurate analysis of data related to depression. |
| 14 | NHS England – Clinical Programmes team |  | Using accurate Snowmed coding will enable accurate data collection. It’s crucial that for the new standard regarding relapse and ethnicity, these are accurately documented with coding rather than just documented in free text. |
| 15 | NHS England & Improvement – Mental Health Transformation Programme (Eastern region) |  | In talking therapies, systems already exist. Not so in secondary care, but would be easy to arrange |
| 16 | NHS England & Improvement - National NHS Talking Therapies team |  | Where IAPT services use a bespoke data collection system (IAPTus or PCMIS) data should be able to be captured for the standards listed from patient records. For commissioned IAPT services not using one of these systems it would prove very difficult to capture the data in a meaningful way. |
|  | **Question 3** |  |  |
| 17 | British Psychological Society |  | The quality standards for mental health services are likely to be unachievable due to limited human resources, long waiting lists and pressures on services leading to closures in some communities. New community-focussed initiatives, such as social prescribing, hold promise for earlier and more holistic support and may result in cost-savings. |
| 18 | Mind |  | As with all guidelines, these statements need to be backed by appropriate training and resource allocation to make them workable – it would be very helpful to get NICE’s assessment on the implications of the new standards for practice. |
| 19 | NHS England – Clinical Programmes team |  | With the use of additional roles and allied health care professionals such as Mental Health Practitioners, these standards can be achieved. There are not any areas for disinvestment, in fact more should be invested into supporting the psychological management of mental health. |
| 20 | NHS England & Improvement – Mental Health Transformation Programme (Eastern region) |  | Not at the moment. Further training in more complex assessment protocols and assessing with cultural sensitivity would be needed for talking therapies, and also some secondary care services and the time taken for assessments would be longer. This could impact wait times, as could support sessions for people who are likely to relapse.  GP’s will decided on dose reduction in medication and should keep in touch with the therapist as this happens, so they can both monitor any unforeseen consequences.  Most services are still set up to deliver therapy in the area that they are designated to work in and then to refer onwards. Using a more holistic approach to assessment and treatment planning will need alignment and change between various systems. For some services it will be fairly straightforward, but for others, it will mean a major rethink.  In both primary and secondary care, workforce problems contribute a significant amount to the wait times for both systems. Looking at how the new roles in secondary care can support this will help, but there is a clear need to address workforce problems with recruitment and retention before these changes would be achievable in the form envisaged. |
| 21 | NHS England & Improvement - National NHS Talking Therapies team |  | These standards should in the main be in line with recommended best practice within IAPT services. The exception is standard 3 regarding group CBT or MBCT - relapse prevention work for adults at a greater risk of relapse after depression. There are unlikely to be enough qualified MBCT practitioners to provide this for the number of patients indicated, suggesting an extensive training need. Many services provide this 1-1 at the end of therapy so that it is tailored to the individual with a practitioner they trust and I am unsure that it improves the patient journey or experience to move them to a CBT or MBCT group at that stage - it may increase the likelihood of them disengaging from services without receiving that important part of the work. |
| 22 | Royal College of Speech and Language Therapists |  | Answer One:  Information in often not provided in easy to read, understandable and accessible formats. This would require a system wide communication as well as local investment.  Answer Two:  Many mental health professionals have not received training to understand communication needs. They will not be aware of these needs nor know how to accommodate these needs. This is a significant gap and impacts on patient care and safety. This will require a training investment. |
|  | **Question 5** |  |  |
| 23 | British Psychological Society |  | No comment |
| 24 | NHS England – Clinical Programmes team |  | There are no specific examples was aware of CVFS and other 3rd sector organisations which work with clinicians offering support to patients. |
| 25 | NHS England & Improvement – Mental Health Transformation Programme (Eastern region) |  | N/A |
|  | **Statement 1** |  |  |
| 26 | British Association for Counselling and Psychotherapy | General | We believe a quality statement focused on assessment should be included but the current version should be expanded to explicitly state that a comprehensive assessment includes a holistic assessment of needs of the whole person and not focus solely on depression.  Taking this approach could help to identify any contributing factors to the individual’s depression (such as social issues around housing, debt etc) as well as helping to inform discussions around which of the recommended interventions might be most effective for the individual. |
| 27 | British Psychological Society | General | Our members tell us that not every adult who may have depression has a comprehensive assessment. Often adults in need of an assessment are put off by the waiting lists that exist. Furthermore, there are a number of adults within the community that are not accounted for in the assessment process because they are unable to access the system.  “The assessment enables an accurate diagnosis of depression or other mental health conditions, such as bipolar disorder and post-traumatic stress disorder. It also supports discussion of ideas and preferences for treatment options”.  This statement may neither feel nor be relevant or inclusive for some service users and may not be holistic. It may be helpful to say “reach a shared understanding of presenting issues” rather than diagnosis, to reflect this.  Similarly, accurate diagnosis does not always lead directly to the type of psychological therapy that would be most appropriate, and it is no help regarding any on-going maintaining factors such as domestic abuse or exploitation by an employer or racism-driven harassment or abuse. Mentioning external agencies such as housing or disability support who could work alongside any healthcare options may be helpful. |
| 28 | NHS England – Mental Health Transformation Programme (Eastern Region) | General | Is there a ‘standard’ for a comprehensive assessment?  Not aware of any routes for recording a comprehensive assessment has taken place.  This would require, especially in primary care, a template for assessment to consider other diagnostic overshadowing potential – physical, menopause, socio-economic factors etc. |
| 29 | NHS England – Mental Health Transformation Programme (Eastern region) | General | This standard should be achievable within IAPT services. The quality standard lists what I would expect to be required in assessment for adults with depression. It should be possible for assessment to take more than one session if this is required by the patient or the nature of the material they wish to discuss. If complex issues are apparent there should be no difficulty in stepping up to a more experienced or differently qualified practitioner. |
| 30 | NHS England – Mental Health Transformation Programme (Eastern region) | General | This is self-evident and should be part of the minimum standard for treatment |
| 31 | Royal College of Speech and Language Therapists | General | Quality statement 1 lacks ambition in how all adults with depression should have an assessment. RCSLT recommend that this is amended to “Adults who may have depression are actively supported to have a comprehensive assessment.  The addition of the “actively support” helps to ensure that the person is involved to actively shape preferences for treatment options.  It is critical that supporting people's voice/input sit at the heart of quality improvement. It speaks to the NICE agenda of improving shared decision making. It also ensures the person’s choices are at the heart of their decision making for treatment options.  Without this change, this quality statement highlights a process which is done to a person as opposed to the person shaping their own healthcare. |
| 32 | Mind | Measures | Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.’ (page 4) This may be covered in other documents, but we wondered if it would be possible to add more detail on this i.e. how and when would patient records be checked to ensure that comprehensive assessments have been carried out? |
| 33 | British Psychological Society | Definitions | A comprehensive assessment includes discussion of factors affecting the development, course and severity of an adult’s depression Pg 4, 5 & 7  Repeated statements of this type could be modified to: “A comprehensive assessment includes discussion of social and environmental factors affecting the development, course, severity and maintenance of an adult’s depression.” this will ensure assessments address the effects of past or current social and environmental factors. Childhood adverse experiences may indicate a need for psychological therapy, and current stressors often require practical help or support if they are maintaining the depression. Maintaining factors must be enquired about, because psychological therapy may be less effective if they are neither asked about nor addressed. Psychological therapists normally ask about them, but they should be considered at every stage, and not only after referral for psychological therapy. |
| 34 | British Psychological Society | Definitions | Although the initial list of four things includes the important issue of “degree of functional impairment or disability”, the main focus is on establishing a diagnostic label rather than understanding how the person has come to be experiencing disabling levels of depression. Even history and duration are descriptive and imply a focus on number of times the person has experienced this level of depression and how long it lasted, rather than what other aspects of their life circumstances they might connect these experiences to. This only comes in the second list, giving a message that it is of less importance. It should be integrated clearly with the first list.  P. 7 “The assessment should include discussion of how the following factors may have affected the development, course and severity of their depression:” Should include “or be maintaining their depression.” The first factor listed again refers to previous depression as if trying to establish something intrinsic to the person, like a disease process, and therefore could overshadow environmental contributors that are essential to understand. |
| 35 | British Psychological Society | Definitions | “Any recent or past experience of stressful or traumatic life events, such as redundancy, divorce, bereavement, trauma” Pg 7  We suggest inclusion of Intimate Partner Violence (IPV) as an example in bullet point concerning any recent or past experience of stressful or traumatic life events, in view of evidence e.g. (https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001439); also include loss events.  The BPS agree with this bullet point. However, it should include “adverse childhood experiences” since there is accumulating evidence that many such experiences can contribute to mental distress in adulthood, including depression (Chapman, D.P., Whitfield, C.L., Felitti, V.J., Dube, S.R., Edwards, V.J. and Anda, R.F., 2004. Adverse childhood experiences and the risk of depressive disorders in adulthood. Journal of affective disorders, 82(2), pp.217-225)  The last bullet point in this list about what to cover during the assessment should have drug and alcohol use separated out. There are two reasons: (1) they need special consideration for services, and (2) lumping them in with “living conditions”, “debt, employment situation, loneliness and social isolation” may overshadow these other very important things that people also need help with. |
| 36 | Mind | Definitions | ‘any recent or past experience of stressful or traumatic life events, such as redundancy, divorce, bereavement, trauma’ (page 7) Evidence supports the inclusion of ongoing life events here, and discrimination i.e. ‘any ongoing, recent or past experience of stressful or traumatic life events, such as redundancy, divorce, bereavement, trauma, discrimination’ |
| 37 | PTSD UK | Definitions | Comprehensive assessment: ‘any recent or past experience of stressful or traumatic life events, such as redundancy, divorce, bereavement, trauma (see the NICE guideline on post-traumatic stress disorder)’ We’d suggest rewording this element where possible to ensure that the timescale of the trauma isn’t overlooked. Perhaps to ‘any stressful or traumatic experiences or life events (recent or in the past as far back as childhood) such as divorce, bereavement, bullying, abusive relationships, assault or work-related incidents.’ (or similar). This ensures that historical instances of trauma are given full consideration and also provides more examples of what is considered ‘traumatic’ – as many people think what they’ve gone through may not be considered as such. |
| 38 | British Psychological Society | Equality & diversity considerations | “The following should be considered…” Pg 8   * “Asking the adult about their symptoms directly, using an appropriate method of communication depending on the person's needs (for example, using a British Sign Language interpreter, English interpreter, or augmentative and alternative communication) * Asking a family member or carer about the adult’s symptoms.”   Some people don’t think of their experiences as “symptoms” when they feel low or have lost interest in usual things. The bullet points could use the language of the two questions about feeling depressed or feeling that there is no hope, or not being able to enjoy things they used to enjoy, asking about what they are experiencing. The same considerations apply to asking family members what they are worried about concerning the adult.  We welcome the recommendation to consult an appropriate specialist in situations where there is acquired cognitive impairment. |
| 39 | Mind | Equality & diversity considerations | ‘asking a family member or carer about the adult’s symptoms’ (page 8) We’d advise amending the wording/formatting here to make it clear that while a conversation with a family member or carer could be part of the assessment, it shouldn’t be relied on by itself i.e. wherever possible the adult should be enabled to communicate their own experiences and needs. |
| 40 | Mind | Equality & diversity considerations | ‘using language which takes into account the person’s family and wider context’ (page 8) We wonder whether more detail could be added here (or in accompanying guidance) about what this would mean in practice? |
| 41 | Royal College of Speech and Language Therapists | Equality & diversity considerations | The equality and diversity considerations section says to ask adult about their language or communication directly. For too long communication needs have remained hidden in people with mental ill-health. A person may not be aware of these or be able to accurately talk about these. It was positive that the NICE depression guideline contained recommendations to improve this situation. However, merely asking someone directly may not give an accurate response. RCSLT recommend that this is reworded. |
| 42 | Royal College of Speech and Language Therapists | Equality & diversity considerations | The equality and diversity consideration also refers to “consulting the relevant specialist”. Would it not be more appropriate to state “consult with a speech and language therapist”. Speech and language therapists are the expert in supporting people with communication needs. RCSLT recommend that this is added, so there is a clear signpost to this support. |
|  | **Statement 2** |  |  |
| 43 | British Association for Counselling and Psychotherapy | General | This statement is an appropriate area for focus however it should be expanded to explicitly state that service users should have a full and informed choice of treatment options and that their care plan is co-created between them and their treatment provider.  Whilst we are supportive of the focus of the guideline being on informed patient choice of treatments, and healthcare providers discussing the full range of treatment options available with patients, it is unclear whether this will be achievable.  A recent survey of GPs found that 61.9% aimed to take patient preferences into account when treating depression, with 12.7% saying that time pressures meant that they made the decision for the patient. In this same study, 41.2% of GPs would consider just talking therapies as the first line treatment, with 68.3% favouring a combination of antidepressant medication and talking therapies (Hegde et al., 2021). Another recent survey (Read et al., 2020) found that the preferred option for GPs in treating ‘moderate/severe’ depression was antidepressants, followed by referral to IAPT services. Furthermore, some research suggests that different types of psychological therapies, their effectiveness and their benefits are not often discussed by GPs (Dumesnil et al., 2018).  Taken together, these findings suggest that a significant culture change will be needed to move away from offering antidepressant medication as the de facto first line treatment for depression, whether alone or in combination with psychological therapies, as well as openly discussing the different modalities of psychological therapies with patients.  It seems very likely that additional training will be needed for GPs and other healthcare professionals to ensure that they feel fully knowledgeable about the different types of psychological therapies in order to provide patients with the full list of treatment options so that they can make a fully informed decision about their own treatment. |
| 44 | British Psychological Society | General | We welcome the statement that all options, including social prescribing and the patient's own ideas based on what has helped previously, should be discussed, and treatment preferences should be routinely recorded. This can help gauge the level of demand for currently unavailable treatments and the reasoning behind these preferences should also be recorded. The current shortage of psychological therapy provision should be acknowledged, and unavailability should not curtail the options discussed. Although discussing unavailable options may be seen as unhelpful, not discussing them contributes to maintaining the shortage and is equally unhelpful because people's preference for unavailable options is not recorded.  Openly acknowledging that patients may have no choice but to accept a non-preferred treatment may also help patient morale because it is honest and sees them as an equal partner in treatment decisions, able to cope with knowing the constraints on the professional. Professionals also may benefit from feeling they can be open. There will be necessary variations to suit different locations and contexts, but some common principles could be widely adopted.  Additionally, depression may co-exist with other diagnoses, and these other diagnoses may sometimes take priority for action and treatment. Access through GPs is hindered by the lack of time available for a full assessment and existing pressures on the system, which takes power from the client to make informed decisions about their care. Access through section can also be problematic, as clients may not want to engage or may not be in a fit state to partake in assessments, which may lead to a missed opportunity for a full range of discussion, including treatment options. |
| 45 | NHS England – NHS England – Mental Health Transformation Programme (Eastern Region) | General | This could have positive benefits regards people being offered psychological interventions before / alongside medication, rather than as an after-thought.  May be challenging to measure in systems – however could be introduced as part of recording against statement 1, by adding an ‘outcome’ of the comprehensive assessment with options such as:  • medication – offered / declined / accepted.  • Psychological treatment referral – offered / declined / accepted. |
| 46 | NHS England – Mental Health Transformation Programme (Eastern region) | General | Yes, but it depends on the experience and ability of the assessor. |
| 47 | NHS England – Mental Health Transformation Programme (Eastern region) | General | This standard should be achievable within IAPT services and is in line with what I would expect to be current practice. |
| 48 | Royal College of Nursing | General | Page 10 onwards, no discussion or mention of ‘recovery orientated interventions’ these are the latest on more grounded interventions currently utilized in mental health services. For example, recovery cafes, recovery colleges, recovery networks, recovery training and opportunities. It is well evidenced family interventions play a key role in recovery in well known depressive diagnosis. |
| 49 | Royal College of Speech and Language Therapists | General | This section refers to Improving Access to Psychological Therapies (IAPT), could this be changed to talking therapies please. |
| 50 | Royal College of Speech and Language Therapists | Rationale | In the rationale for QS2, RCSLT recommend adding in that the choice of treatment is matched to communication and cognitive abilities. At present this is missing.  This change would drive better treatment options and adherence to that treatment too. Supporting people’s choice and voice must sit at the heart of reforms to improve mental health services. |
| 51 | British Psychological Society | Measures | Outcome measure a):  The BPS welcomes the aspiration stated in this outcome measure However, the extent of collaboration is very difficult to establish in practice and there’s a need to clarify understanding and expectations. The BPS suggest one measure of full involvement would be if people felt they have been given treatment choices to choose between, e.g. “They are given information about …..including, social prescribing (if relevant), the different modalities of psychological therapy (eg., CBT, IPT); |
| 52 | Royal College of Nursing | Definitions | Regarding Question 1:  Page 14- PHQ 9 is good as a brief or rather community intervention tool, consider the HAMILTON. |
| 53 | British Psychological Society | Audience descriptors | Regarding the statement: “Service providers (such as GP practices, IAPT services and NHS acute and mental health trusts) ensure that pathways, service protocols and capacity are in place so that adults with a new episode of depression can express a preference for treatments, and that these are available in a timely manner (particularly for adults with severe depression),”  There should be a system for recording barriers to putting such pathways, protocols, and capacity in place, and for feeding back this information to the relevant body since the lack of capacity may be due to a national skill shortage, insufficient funding, or other factors that are not within the immediate control of NHS trusts, GP practices or services. |
| 54 | British Psychological Society | Audience descriptors | We welcome the discussion of waiting times is included in advice for healthcare professionals. |
| 55 | British Psychological Society | Audience descriptors | The statement on what the quality standard means for adults with a new episode of depression is an important and useful inclusion. |
| 56 | Royal College of Speech and Language Therapists | Equality & diversity considerations | In the equality and diversity considerations RCSLT agree that all information, provided to all adults with depression, should be easy to read and understand and in an appropriate format. Thank you for adding this. |
| 57 | Royal College of Speech and Language Therapists | Equality & diversity considerations | The equality and diversity considerations highlights adjustments to the delivery of treatments. However, there is a lack of detail about delivery face to face in person or telephone/video. For many people with communication needs, remote delivery online, via video or telephone, can be inappropriate or not accessible. RCSLT would like to see this consideration taken into account in this quality standard 2.  This change would ensure that services are more person centred. |
|  | **Statement 3** |  |  |
| 58 | British Psychological Society | General | Our members tell us this is not consistently happening due to funding constraints and a lack of qualified staff. The emphasis in this section is mainly on treating depression, but as previously mentioned, environmental and social factors that contribute to and maintain depression should also be addressed. These factors may include discrimination, exploitation, abuse, debt, and other stressors. If these factors have not been addressed, individuals should be signposted to agencies that specialize in these issues or receive active support in accessing them. All professionals should understand the effects of poverty, unemployment, exploitation, abuse, institutional racism, and other structural factors that affect a person’s well-being, and work together to combat these or at least be aware of them and work with other relevant agencies to ensure individuals receive the support and protection they need. |
| 59 | NHS England & Improvement – Mental Health Transformation Programme (Eastern region) | General | Agree, but given staffing problems, this would be difficult to put into practice |
| 60 | NHS England & Improvement- National NHS Talking Therapies team | General | This standard will be more difficult to meet in practice within IAPT services. Many services do not have the number of qualified MBCT practitioners required to offer this service to all patients with depression who may be at greater risk of relapse. There would need to be investment into increasing this workforce should this standard be introduced, and this would take time as training is at least 12 months and is an intensive training requiring significant time out of clinical practice during the training period to meet the course requirements. This would affect a clinician’s capacity to deliver other clinical services whilst training. Many services do not offer structured group CBT or MBCT for relapse prevention but incorporate 1-2 sessions of relapse prevention work into the end of 1-1 therapy. I wonder about the impact on patients of having to move to a group/new practitioner to do this work when they have built a therapeutic and trusting relationship with their individual therapist. It may lead to patients dropping out of their intervention and not receiving this work at all. This may also lead to undue delays for patients who have to wait for a group to commence. I also wonder how many sessions it would be proposed for these groups to run as this may present an additional demand on workforce. |
| 61 | British Psychological Society | Measures | The quality measures regarding interventions for relapse prevention should include the number of people who were asked about on-going stressors that may be maintaining their depression, and the number of those where such stressors were identified, who were signposted or supported to access appropriate agencies for support with these stressors. |
| 62 | British Psychological Society | Audience descriptors | As previously mentioned, the identification of ongoing stressors and environmental factors should form part of depression identification and treatment. As such, this be reflected in this section and tailored for the specific audiences.  For adults with depression this should include that they should expect to be asked about any on-going stressors that may be continuing to contribute to their depression, whether they have been able to access support with those things, and that they should expect signposting or active support to access relevant agencies. All these suggestions are consistent with the definition on p. 17 of people who are at higher risk of relapse, which includes: “personal, social or environmental factors contributed to depression and that are still present (for example, relationship problems, ongoing stress, poverty, isolation, unemployment).” |
| 63 | British Psychological Society | Definitions | Page 18.  The following phrase: “identifying stressful circumstances, triggering events, warning signs (such as anxiety or poor sleep), or unhelpful behaviours (such as avoidance or rumination) that have preceded worsening of symptoms and personal or social functioning, and making detailed contingency plans of what to do if each of these re-occur,” conflates two issues. Identifying stressful circumstances is important on its own and should not be combined with assumptions about an individual’s “unhelpful behaviours.” |
| 64 | Mind | Definitions | ‘personal, social or environmental factors contributed to depression and that are still present (for example, relationship problems, ongoing stress, poverty, isolation, unemployment)’ (page 17) As with statement 1, we’d advise adding ‘discrimination’ here. |
|  | **Question 4** |  |  |
| 65 | British Psychological Society |  | Current information systems make it difficult to accurately report on individuals with a high risk of relapse after being discharged from mental health services. There is limited support and monitoring leading to a lack of follow-up on their wellbeing. Environmental factors and a lack of advocacy for support groups further impact recovery and management of symptoms. |
| 66 | NHS England – Clinical Programmes team |  | Yes with thorough history especially looking at background of depression, family history ad also crucially, the socioeconomic factors, these patients should be identifiable. Working closely and encouraging engagement of patient with mental health practitioners will also help to identify these patients. |
| 67 | NHS England & Improvement – Mental Health Transformation Programme (Eastern region) |  | On paper yes. But there will always be some who mask symptoms and feelings of wanting self-harm, or of hopelessness as all assessments and indeed most rating scales rely on patient self-report and then professional interpretation. Doing a holistic assessment as suggested in the document can help reduce this as it can tease out lifestyle and relationship stressors that could contribute to a future relapse after treatment.  Having good rating scales which also record the self-reported level of social and economic stressors would help to give a baseline standard for assessment and can then be compared with what the assessor uncovers in the session, to make a more accurate judgement.  It is important that assessors receive adequate training in doing complex and multidimensional assessments, as well as being trained to understand the impact of physical health problems on mental health and how this might also make a relapse more likely. It is important that experienced therapists/psychologists do most assessments to read the patients’ needs more accurately. |
| 68 | NHS England & Improvement - National NHS Talking Therapies team |  | [Below answer from the perspective of gathering information to measure against the quality statement – rather than clinical decision-making with individual patients at the point of deciding if a patient is offered relapse prevention interventions]  Some elements of the ‘high risk of relapse’ definition may be stored as free-text responses in the patient record and any elements that are in any way subjective would make it harder to identify quickly and efficiently – either through manual search or an automated process.  This would make the collection of data for the numerator highlighted in the guidance quite time-consuming and less practical given the current pressures on services.    To automate the process by developing a risk stratification tool/case finding tool there may need to be a research/audit project to develop the identifying code, to ratify, and to externally validate the results to ensure bias is avoided. If these tools have already been developed it would ease the burden on collecting the information for audit/to measure against the quality standard. |
|  | **Statement 4** |  |  |
| 69 | British Association for Counselling and Psychotherapy | General | We recognise that stopping or reducing antidepressant medication is a priority for a significant proportion of patients. However, one of the main barriers to this is the withdrawal symptoms that patients might experience. Most commonly, these include anxiety, delirium, lethargy, tremors, and mania (Framer, 2021; Horowitz et al., 2021; Davies & Read, 2019; Moncrieff et al., 2020). However, there is a paucity of high-quality research available on the process of withdrawal and there is no consistent guidance on the best way to do this (Boland et al., 2022). A recent priority setting partnership (PSP) has been developed to identify and prioritise gaps in knowledge around tapering medication (Boland et al., 2022). Whilst we support the notion of antidepressant tapering in line with patient choice, we remain mindful of the lack of available evidence and recommend that patients experiencing withdrawal symptoms have access to on-going support to help manage and alleviate these symptoms. |
| 70 | British Psychological Society | General | Whilst this is an ideal position, our members note that it is not the case that this occurs consistently and systematically.  We would like to highlight guidance produced by BPS in association with BPS, BACP, UKCP and others on withdrawing from prescribed drug  (Guy, A., Davies J., Rizq, R. (Eds.) (2019). Guidance for psychological therapists: Enabling conversations with clients taking or withdrawing from prescribed psychiatric drugs. London: APPGfor Prescribed Drug Dependence) |
| 71 | NHS England & Improvement – Mental Health Transformation Programme (Eastern Region) | General | Unclear how this can be measured. |
| 72 | NHS England & Improvement – Mental Health Transformation Programme (Eastern region) | General | This should be standard practice already. Medication should be more tightly monitored |
| 73 | NHS England & Improvement - National NHS Talking Therapies team | General | This would appear to be best practice and could be supported but not implemented by IAPT services as GP/RMO would need to initiate and monitor medication change.  1. Does this draft quality standard accurately reflect the key areas for quality improvement?  YES  2 Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?  The proposal to use local systems to capture the data is likely to lead to substantial variation in the quality of data capture. I would strongly advise steps should be taken to enable national prescribing data systems to be enabled to capture the data for measuring this quality standard. |
| 74 | Royal College of Nursing | General | Regarding Question 3:  Page 19- as an experienced prescriber extreme vigilance is needed when coming of anti-depressant medication, perhaps consider alternative pharmacological medications, i.e., adjunct therapy or cross prescribing of anti-depressant medications with lesser withdrawal i.e., citalopram from fluoxetine.  Consultation, monitoring, GP reviews, consultant psychiatry appointments are useful. |
| 75 | Royal College of Speech and Language Therapists | General | Whilst quality statement 4 is on stopping antidepressants, RCSLT cannot see a statement on restarting antidepressants after a period of absence. If this is meant to fit back into a loop of QS1, maybe this could be added for clarity. |
| 76 | Mind | Rationale | Any withdrawal symptoms need to have been resolved or be tolerable before making the next dose reduction’ (page 19) Would it be possible to include some detail here about how this is decided e.g. will the patient have an appointment to check-in before making the next dose reduction? |
|  | **Statement 5** |  |  |
| 77 | British Association for Counselling and Psychotherapy | General | The quality statement should be broadened to ensure all people from marginalized communities, including race, but also including age, disability, gender, sexuality, language etc. are supported to access mental health systems.  A ‘one-size-fits-all’ approach is an ineffective strategy for meeting the needs of diverse populations (Mantovani et al., 2016). Thus, to ensure that services are more congruent with their patients’ needs, providing a culturally sensitive service is suggested to improve accessible and/or acceptable mental health treatments. For instance, qualitative findings suggest cultures present differences in health beliefs, as well as cultural, language and religious barriers (Loewenthal et al., 2012). Research therefore suggests developing specialist primary mental health care and/or culturally sensitive GP services which focus on understanding socio-cultural issues within the specific communities as well as recognising shared common features. For instance, improving awareness and understanding of cultural and religious influences which may affect access and referral to mental health services. In doing so, this will improve understanding on how these cultural interpretations may impact on potential access and may therefore decrease stigma.  Culturally sensitive services may also include individuals opting to receive treatment which is specific to their culture and/or identity, such as client-therapist racial/ethnic matching. When examining racial/ethnic matching, a systematic review and meta-analysis found that individuals of an ethnic minority reported: (1) a moderately strong preference for a therapist of one’s own race/ethnicity; (2) a tendency to perceive therapists of one’s own race/ethnicity somewhat more positively than other therapists; and (3) almost no benefit to treatment outcomes from racial/ethnic matching of clients with therapists (Cabral & Smith, 2011). In other words, individuals tend to prefer having a therapist of their own race/ethnicity. Despite this, once patients enter a therapeutic relationship, emphasis of race/ethnicity for positive evaluation of the therapist and treatment outcomes decreases. This may contextualise findings of services not having to be BAME specific (e.g., having a counsellor of the same ethnicity) or based in BAME community organisations, as well as being located near their place of residency (Pacitti et al., 2011).  The locality of services has also been identified as an important factor for improving accessibility. In one scoping review, locations and schools were found as a common source of support, highlighting the importance of services beyond traditional routes (Vahdaninia et al., 2020). This may also be relative to the nature of care pathways for Black people, which were found to negatively impact both the outcome of treatment and willingness to engage with mainstream services (Vahdaninia et al. 2020). As such, ethnic minority patients emphasised the importance of statutory and voluntary sector community support services in their recovery, due to pertaining a more holistic approach to overall health (Keynejad, 2009). Whilst community settings are found to reduce stigma, research suggests that there is still a need to examine the effectiveness of identity specific services (e.g., BAME), as well as indicate their suitability among mainstream mental health services (Vahdaninia et al. 2020).  Mental health services should also consider language barriers when promoting easy and flexible access, particularly among communities whose first language is not English (e.g., forced migrants; Palmer et al., 2007). Qualitative research suggests the need to develop training for interpreters to have more relevant knowledge of dialects, as well as greater awareness of confidentiality in culturally sensitive areas (Knifton, 2012). For instance, findings from focus groups among Pakistani, Indian, and Chinese heritage communities reflect the need for community dialogue and/or workshops to be culturally appropriate in order to improve access to support (Knifton, 2012). Further, to self-improve access to support, newer or first-generation migrants with lower English language ability sought assistance from religious leaders or respected members of their community with whom they can communicate more easily. Hence, individuals expressed that those services delivered by people from within their community may improve in effectiveness (Rabiee & Smith, 2014). This finding is not novel, as this has been found among many other minority groups who experience other ranging health difficulties. |
| 78 | British Psychological Society | General | Adults with depression from minority ethnic family backgrounds face barriers in accessing mental health services, as they often do not receive culturally appropriate assessments that take into account the wider social context in which they live. Despite these challenges, it is important to acknowledge the diversity of ethnic and cultural self-identification among individuals from ethnic minority backgrounds, including differences in language, ethnicity, nationality, family patterns, religion, and spirituality. These similarities and differences between and within groups are significant in shaping the experiences related to access to services and satisfaction with mental health care. |
| 79 | Mind | General | We welcome this statement and wanted to check whether there are plans to add similar statements to guidance regarding other mental health problems? |
| 80 | NHS England & Improvement – Mental Health Transformation Programme (Eastern Region) | General | Agree this would be useful, as would access by some other seldom heard groups |
| 81 | NHS England – Mental Health Transformation Programme (Eastern region) | General | Again, this should be standard practice already. Maybe include adjusting for different groups in therapy training courses |
| 82 | NHS England & Improvement - National NHS Talking Therapies team | General | This standard is in line with best practice outlined in the IAPT BAME Positive Practice Guide and should be achievable within IAPT Services |
| 83 | Royal College of Nursing | General | Regarding Question 4:  Page 22 is a little descriptive as a person from an ethnic minority background it is important to discuss support, translation services, cultural differences, expectations and prayer facilities being made available early on in the draft- these pointers are drafted a bit late. (Only suggestion) |
| 84 | Mind | Measures (outcomes) | We wondered whether it would be in the scope of this statement to highlight the need for improved treatment outcomes for people from ethnic minority backgrounds, as well as improved access? |
| 85 | British Psychological Society | Audience descriptors | The list of services that is represented here is most welcome as it seems highly relevant for improving access to services; however, resources are likely to be variable for local services and networks – for example: services are not usually available outside normal working hours; in community settings, there can be confidentiality issues and there are likely to be workforce issues for bilingual therapists. |
|  | **Additional areas** |  |  |
| 86 | NHS England – Clinical Programmes team | General | Quality standards 1 – 3 focus on prevention, but there is no inclusion of support to treat tobacco dependence and support smoking cessation. Can this be included?  Data from the Prescribing Observatory for Mental Health (POMH) audit done by the Royal College of Psychiatrists was submitted to support this suggestion. The audit is available to members only and can be found [here](https://www.rcpsych.ac.uk/improving-care/ccqi/national-clinical-audits/pomh#:~:text=The%20Prescribing%20Observatory%20for%20Mental%20Health%20%28POMH%29%20is,focus%20on%20specific%20topics%20within%20mental%20health%20prescribing.). |
|  | **Advised no comments** |  |  |
| 87 | Prescribing Observatory for Mental Health (POMH) | N/a | N/a |
| 88 | Royal College of General Practitioners | N/a | N/a |

Note: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

## Registered stakeholders who submitted comments at consultation

* British Association for Counselling and Psychotherapy
* British Psychological Society
* Mind
* NHS England & Improvement:
  + Clinical Programmes team
  + Mental Health Transformation Programme (Eastern region)
  + National NHS Talking Therapies team
* NHS Specialist Pharmacy Service - UK Drugs in Lactation Advisory Service
* Prescribing Observatory for Mental Health (POMH) - advised no comment
* PTSD UK
* Royal College of General Practitioners – advised no comment
* Royal College of Nursing
* Royal College of Speech and Language Therapists